

PATIENT INFORMATION

DATE _____

NAME _____
LAST FIRST M MARRIED SINGLE MINOR MALE FEMALEADDRESS _____
STREET APT.# CITY STATE ZIPBIRTH DATE _____ TELEPHONE _____
MONTH DAY YEAR HOME # WORK #

PLACE OF EMPLOYMENT _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

Has any member of your family ever been treated in our office? YES NO

Whom may we thank for referring you to our office? _____

FAMILY INFORMATIONFILL IN BOTH SHADED BLOCKS FOR MINOR CHILD.
FILL IN APPROPRIATE SHADED BLOCK FOR ADULT.**FATHER (OR HUSBAND)**

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER# GROUP#

MOTHER (OR WIFE)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER# GROUP#

**PERSON TO CONTACT
IN CASE OF EMERGENCY**

Outside of Immediate Family/Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
 Adult Patient Father (Or Husband) Mother (Or Wife) Guardian

Date _____ State Driver's License # _____

**PERSON RESPONSIBLE
FOR ACCOUNT**

Please Check One

-
- Patient
-
- Father (Or Husband)
-
-
- Guardian
-
- Mother (Or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office

-
- YES
-
- NO

-
- Payment in full at each appointment (cash or personal check)
-
-
- Payment in full at each appointment (
-
- VISA
-
- MC)

-
- I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$3.00 for a balance under \$200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.